Wyoming Department of Health
Commit to your health.

Mental Health and Substance Abuse Services Division

Children's Mental Health Waiver

Individual Service Plan/Budget

Name of Youth:
Address *(number and street, city, state, zip code)*:
Date of Birth:
Social Security Number:
Preferred Language of Communication: ☐ English ☐ Spanish ☐ Other: _____ **Do Youth/Family have interpreter available?** ☐ Yes ☐ No ☐ N/A If "Yes", please identify :
Is the Child/Youth currently receiving Medicaid? ☐ Yes Medicaid Number: ☐ No, Medicaid Number Pending **Other Insurance *(specify):***
Level of Care Evaluation date (CASII):
ISP Meeting date: **ISP Start date:** **ISP End date :**
Name of Legally Responsible Individual: **Relationship to Youth:** ☐ Parent ☐ Legal Guardian ☐ Attorney ☐ Other *(please specify)*: *(For relationship other than parent, please submit written / legal documentation with plan)*
Address (*if different from youth address above – include e-mail address)*:
Telephone Number:
Family Care Coordinator *(name, address, e-mail address, phone number)*:

Form #: WP-1
Implementation Date: 71//06 Revision Date: 2/1/07, 9/1/07

Children's Mental Health Waiver

Participant Rights and Responsibilities

As a participant of the home and community-based waiver for children with serious emotional disturbance, the youth served and his/her family have the following rights:

- To explanation of and decision making abilities regarding the choice of all waiver and non-waiver services.
- To choose a Family Care Coordinator, any duly licensed/certified mental health professional, and all other waiver service providers.
- To be informed about options available for treatment interventions and the effectiveness of the recommended treatments.
- To make final decisions about treatment.
- To be free from abuse, undue restraints, unnecessary drugs, and discrimination because of race, national origin, sex, religion, or disability.
- To receive individually tailored services provided in the least restrictive environment.
- To evaluate services provided by the Children's Mental Health waiver.
- To be protected from state intrusion except for the absolute minimum extent necessary to achieve appropriate waiver services and supports.
- To confidential protection of information provided to determine waiver eligibility, provide and bill for waiver services, and monitor waiver quality, or except in cases of suspected abuse or neglect or if your child threatens to harm him/herself or others.
- To receive written procedures for how to file a grievance or request a hearing regarding services that are being provided.
- To be notified and receive emergency contact information or a back-up contact for your Family Care Coordinator when he/she is unavailable.

The youth served and his/her family have the following responsibilities:

- Assist in collecting necessary data and documentation (including medical records, school/IEP related information, etc.).
- Choose waiver services and providers.
- Attend and participate in plan development and review meetings.
- Review final service plans to ensure it reflects the services and supports that you require and agreed to.
- Keep appointments with your Family Care Coordinator, Team members, and for all plan services.
- Assure that necessary medical information and emergency and contact information is shared with all applicable providers.
- Utilize ALL services identified and provided through the plan.
- Carry out responsibilities that are identified for you in the plan.
- Ask questions about your direct responsibilities if information or directions are not understood.
- Provide all information to your Family Care Coordinator and team members as it relates to carrying out the plan.
- Inform your Family Care Coordinator and/or providers of concerns and questions you have and give them an opportunity to address those concerns.
- Abide by all rules and regulations of the waiver program as well as rules, laws, and expectations of the community.
- Provide timely information to your Family Care Coordinator about incidents, medication concerns, behavior concerns, and other important information.
- Notify your Family Care Coordinator of change in residence and/or telephone numbers.
- If you are a court-appointed guardian, provide information to the courts at least twice a year or as required by court documents.

Relevant Medical Information

Diagnosis

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

Medications (*List ALL medications the youth is currently taking.)*

Medication (dose/frequency)	Start Date	Diagnosis Target Symptoms	Prescriber	Date of Last Review	Frequency of Ongoing Reviews

Has Youth/family given informed consent for all behavior/psychotropic medications currently being taken?

- ☐ Yes *(if written consents are available, please attach to ISP document).*
- ☐ No *(Outline the plan to obtain consent forms FCC-6 or consents from other facility).*

Assessments/Evaluations

What Assessments were reviewed with the Family Care Team?

- ☐ Family Assessment
- ☐ Youth Health and Safety Review
- ☐ Family Care Team Assessment(s) for which service(s):
- ☐ Psychological Evaluation (if not available for Initial ISP, discuss need and identify specific areas of focus)
- ☐ Other(s) *(please specify)*

Are there assessments that need to be completed or referrals made within this plan period?

- ☐ Yes *(please identify and outline plan to obtain).*
- ☐ No

Family Vision

(Tell me what you want things to look like for you and your family a year from now.)

Domains/Strengths/Needs

(*List related strengths and needs for all domains. Focus on strengths/preferences that can be used to obtain the wants and needs. List wants and needs as "Jane needs to complete fourth grade" or "Jane's mom wants her to go to church with her".)*

Under each domain heading, provide general description of the child/youth's current situation. *(i.e. Home: "Jane lives at her grandmother's house with her mom and two younger brothers.")*

Domains	Preferences/Strengths	Wants/Needs
Home		
Vocational/ Educational		
Community		
Leisure/Recreation		
Socialization		
Health		
Financial/ Economic		
Legal		
Other (Behavior)		

Outcome Objectives

(*Describe what things will look like when the need is met – in measurable terms. Example: "Jane will attend school daily and complete required class work to allow her to pass ninth grade".)*

Action Steps AND Anticipated Completion Date	Responsible Person AND Type of Support	Duration/ Frequency	Methods for Monitoring and Measuring

Start Date to Begin Work on this Outcome Objective:

Projected date for Completing Outcome Objective:

Updates

Action Steps AND Anticipated Completion Date	Responsible Person AND Type of Support	Duration/ Frequency	Methods for Monitoring and Measuring

Start Date to Begin Work on this Outcome Objective:

Projected date for Completing Outcome Objective:

Updates

Behavior Support Plan

(Utilize "Information to Develop a Behavior Support Plan" document to assist in development of a support plan.)

Include brief description of what the Behavior Support Plan is, anticipated benefits, and why it is necessary.

For Initial ISP:

☐ Yes - Attach completed ISP Behavior Support Plan document (FCT-6 form)

☐ No - Provide Team rationale for why not OR the Team's plan to develop a Support Plan.

Updates (*Include # of time BSP was used, was it successful, what changes were made and why, have new behaviors been identified – positive or negative)*

Team Meeting Minutes

(Summarize meeting discussions, conclusions, and any assignments given not documented elsewhere in the plan.)

Plan Development Team

(Complete requested information for all Team members)

Name	Relationship to Youth/Family	Involvement Code	Telephone	Address	

Team members have participated in plan development by submitting reports and/or attending planning meeting.

Involvement Codes: P = Present at planning meeting (in person or by telephone)
A = Completed assessment prior to planning meeting
C = Contacted to obtain in formation prior to planning meeting

Wyoming Mental Health & Substance Abuse Services Division
Pre-Approval for Children's Mental Health Waiver Services

Name of Youth: _____Medicaid ID # 06-_____

Individual Service Plan Date: _____ Family Care Coordinator: _____

Service Code	Service Type	Service Provider Number (9 digits)	Provider Name	Units to be Used (3 months)	Unit Rate	Total Cost (3 months)
T1016	Family Care Coordination				$12.00	
T1027	Family Training and Support				$7.00	
H0023	Individualized Child Training and Support				$4.50	
A = TOTAL QUARTERLY COST FOR HCBS WAIVER CARE =						**$**

_____

Signature of Parent/Guardian/Responsible Person Date

_____

Signature of Family Care Coordinator Date

☐ Approved by MHD _____

Signature Date

Please identify the mental health and medical services to be provided in support of this waiver plan.

Medicaid Mental Health Services

Clinical Assessment Provider:	Units per quarter =		x Unit Cost $ (15 min)	19.50
Agency-Based Individual/Family Therapy Provider:	Units per quarter =		x Unit Cost $ (15 min)	19.50
Community-Based Individual/Family Therapy Provider:	Units per quarter =		x Unit Cost $ (15 min)	25.00
Individual Rehabilitative Services Provider:	Units per quarter =		x Unit Cost $ (15 min)	6.70
Comprehensive Medication Services Provider:	Units per quarter =		x Unit Cost $ (15 min)	19.50
Psychiatrist Services Provider:	Visits per quarter =		x Cost $	
Behavior Health Service Physician, other than Psychiatrist Provider:	Visits per quarter =		x Cost $	
Advanced Practitioner of Nursing Provider:	Visits per quarter =		x Cost $	
Other Provider:	Visits per quarter =		x Cost $	
B = TOTAL ESTIMATED QUARTERLY COST FOR MEDICAID COVERED MENTAL HEALTH SERVICES =				

Medicaid Medical Services

Clinic/Rural Health Clinic Services Provider:	3 mo. payment history =
Pharmacy Provider:	3 mo. payment history =
Early & Periodic Screening, Diagnostic & Treatment Services and Immunizations (EPSDT) Provider:	3 mo. payment history =
Therapy (PT / OT / Speech) Provider:	3 mo. payment history =
Family Planning Provider:	3 mo. payment history =
Dental Provider:	3 mo. payment history =
Laboratory & X-ray Services Provider:	3 mo. payment history =
Transportation services for doctor, hospital, and other health care visits Provider:	3 mo. payment history =
ESTIMATED QUARTERLY COST FOR OTHER MEDICAID STATE PLAN SERVICES =	

A = TOTAL QUARTERLY COST FOR <u>HCBS WAIVER CARE</u> =	$
B = TOTAL QUARTERLY COST FOR <u>MEDICAID COVERED MENTAL HEALTH SERVICES</u> =	$
TOTAL AMOUNT FOR HOME AND COMMUNITY – BASED SERVICES (A+B) = *(An Exceptional Plan Request must be submitted with this plan if this amount > $7000)*	$ **MUST BE < $7000**
ESTIMATED PSYCHIATRIC HOSPITAL COSTS (FOR 90 DAY STAY) =	**$ 7,893.00**

Read and initial each item before signing:

_____ Available services were discussed with me prior to and during the service planning process.

_____ My input was requested and incorporated into the development of this plan.

_____ I was given information about certified waiver providers and chose the providers I/ my family wish to work with.

_____ I understand my rights and responsibilities as a waiver participant and agree to exercise my rights and adhere to my responsibilities as outlined in this plan.

_____ I understand that each service provider identified in this plan will receive a copy of the plan which should contain what was agreed upon by Team Members. It has also been explained to me that information about this plan and services being provided will be monitored by the Wyoming Department of Health, Mental Health and Substance Abuse Services Division and/or Centers for Medicare and Medicaid Services. Information used for these monitoring activities will be used by authorized personnel only.

Signature of Youth/Legally Authorized Person: _____ Date: _____

The Plan of Care has been carefully planned and coordinated with the active involvement of the youth and family. Necessary personnel and the youth and family will monitor and evaluate this plan on a regular basis for its continuing appropriateness. This Plan of Care is a true reflection of discussions and recommendations submitted in the development of the plan. By signing, I also acknowledge the confidential nature of the information presented and discussed.

Signature of Family Care Coordinator: _____ Date: _____

Wyoming Department of Health
Commit to your health.

☐ Approved by MHD _____ Date: _____